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**BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against:)

WILLIAM M. LIEBMAN, M.D.)

Physician and Surgeon's Certificate No. G 12827)

Respondent.)
_____)

File No. 12-1999-98182

ORDER GRANTING STAY

On July 6, 2000, John P. Wagner, attorney for Respondent, William Liebman, M.D., filed a request for a stay of execution of the Decision in this matter with an effective date of July 10, 2000 at 5:00 p.m.

Execution is stayed until July 16, 2000.

This stay is granted solely for the purpose of allowing Dr. Liebman to lose all rights and privileges to practice as a physician and surgeon in the State of California on August 15, 2000.

DATED: July 10, 2000

**DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA**

By: _____

Elberta Portman

Elberta Portman
Staff Services Manager

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation)
Against:)

WILLIAM LIEBMAN, M.D.)
Certificate No. G-12827)

No: 12-1999-98182


Respondent)

DECISION

The attached Stipulation for Surrender of License is hereby adopted by the Division of Medical Quality as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on July 10, 2000.

IT IS SO ORDERED July 3, 2000.

By: 
IRA LUBELL, M.D.
President
Division of Medical Quality

BILL LOCKYER, Attorney General
of the State of California
KERRY WEISEL, State Bar No. 127522
Deputy Attorney General
California Department of Justice
1515 Clay Street, Suite 2000
Oakland, California 94612
Telephone: (501) 622-2145
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 12 1999 98182

WILLIAM LIEBMAN, M.D.
2620 Northgate Mall
San Rafael, California 94403

STIPULATION FOR SURRENDER
OF LICENSE

Physician's and Surgeon's Certificate No. G 12827

Respondent

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the
above-entitled proceedings, that the following matters are true:

1. Complainant, Ron Joseph, is the Executive Director of the Medical Board
of California, Department of Consumer Affairs ("Board") and is represented by Bill Lockyer,
Attorney General of the State of California by Kerry Weisel, Deputy Attorney General.

2. William M. Liebman, M.D. ("respondent") is represented in this matter by
attorneys John P. Wagner and Robert J. Sullivan of the law firm of Nossaman, Guthner, Knox &
Elliot, LLP. Respondent has consulted with his attorneys concerning the effect of this stipulation
which respondent has carefully read and fully understands.

3. Respondent has received and read the Accusation, which is presently on
file and pending in Case Number 12 1999 98182 before the Division of Medical Quality of the

1 Medical Board of California, Department of Consumer Affairs ("Division"). A copy is attached
2 as Exhibit A and incorporated in this stipulation by reference.

3 4. Respondent agrees that his license history is as set forth in the Accusation.

4 5. Respondent understands the nature of the charges alleged in the
5 Accusation and that, if proven at hearing, such charges and allegations would constitute cause for
6 imposing discipline upon respondent's license issued by the Board.

7 6. Respondent and his counsel are aware of each of respondent's rights,
8 including the right to a hearing on the charges and allegations, the right to confront and cross-
9 examine witnesses who would testify against respondent, the right to testify and present evidence
10 on his own behalf, as well as to the issuance of subpoenas to compel the attendance of witnesses
11 and the production of documents, the right to contest the charges and allegations, and other rights
12 which are accorded respondent pursuant to the California Administrative Procedure Act
13 (Government Code section 11500, *et seq.*) and other applicable laws, including the right to seek
14 reconsideration, review by the superior court, and appellate review.

15 7. For the purpose of resolving Case No. 12 1999 98182 without the expense
16 and uncertainty of further proceedings, respondent gives up his right to contest, as set forth in
17 paragraph 6, above, that cause for discipline exists based on the charges in the Accusation and, in
18 addition, admits to the Second Cause for Discipline contained in the Accusation. Respondent
19 agrees to surrender his physician's and surgeon's certificate for the Division's formal acceptance.
20 The Board agrees to waive the costs of investigation and enforcement of this matter except as
21 provided in paragraph 12, below.

22 8. All admissions and recitals contained in this stipulation are made solely
23 for the purpose of settlement in this proceeding and for any other proceedings in which the
24 Division of Medical Quality, Medical Board of California or other professional licensing agency
25 is involved, and shall not be admissible in any other criminal or civil proceedings.

26 9. Respondent understands that by signing this stipulation he is enabling the
27 Division of Medical Quality to issue its order accepting the surrender of his license without
28 further process. He understands and agrees that Board staff and counsel for complainant may

1 communicate directly with the Division regarding this stipulation, without notice to or
2 participation by respondent or his counsel. In the event that this stipulation is rejected for any
3 reason by the Division, it will be of no force or effect for either party. The Division will not be
4 disqualified from further action in this matter by virtue of its consideration of this stipulation.

5 10. Upon acceptance of the stipulation by the Division, respondent
6 understands that he will no longer be permitted to practice as a physician in California.

7 11. Respondent fully understands and agrees that if he ever files an application
8 for relicensure or reinstatement in the State of California, the Division shall treat it as a petition
9 for reinstatement, respondent must comply with all the laws, regulations and procedures for
10 reinstatement of a revoked license in effect at the time the petition is filed, and all of the
11 allegations and Causes for Discipline contained in the Accusation in Case No. 12 1999 98182
12 will be deemed to be true, correct and admitted by respondent when the Division determines
13 whether to grant or deny the petition. Respondent agrees that he will not petition for
14 reinstatement for at least three years following the effective date of this petition and that, if he
15 does seek reinstatement, he will provide the Marin County District Attorney's office with a copy
16 of his petition for reinstatement at the same time as he files the petition with the Medical Board
17 and that he will provide the board with evidence that he has so notified the District Attorney.
18 Respondent hereby waives any time-based defense he might otherwise have to the charges
19 contained in the Accusation in Case No. 12 1999 98182 including but not limited to the equitable
20 defense of laches.

21 12. If the Board grants future reinstatement, respondent agrees to reimburse
22 the Board for its costs of investigation and enforcement of this matter in the amount of
23 \$44,400.00 payable to the Board upon the effective date of such reinstatement Decision.

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DATED:

6/16/00

I concur in the stipulation.

Dated: 6-13-00

John P. Wagner

JOHN P. WAGNER
ROBERT J. SULLIVAN
NOSSAMAN, GUTHNER, KNOX & ELLIOT, LLP

Attorneys for Respondent

Dated: 6/23/2000

BILL LOCKYER, Attorney General
of the State of California

Ken Weibel

KERRY WEISEL
Deputy Attorney General

Attorneys for Complainant

1 BILL LOCKYER, Attorney General
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6 Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 9, 20 00
BY Kimberly Kuchner ANALYST

7
8
9 BEFORE THE
MEDICAL BOARD OF CALIFORNIA
10 STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 12 1999 98182

12 WILLIAM LIEBMAN, M.D.
2620 Northgate Mall
13 San Rafael, California 94403

ACCUSATION

14 Physician's and Surgeon's Certificate No. G 12827

15 Respondent

16
17 Complainant alleges:

18 PARTIES

19 1. Ronald Joseph ("Complainant") brings this accusation solely in his official
20 capacity as the Executive Director of the Medical Board of California.

21 2. On or about November 12, 1967, the Medical Board of California issued
22 Physician's and Surgeon's Certificate Number G 12827 to William Liebman, M.D. ("Dr.
23 Liebman" or "respondent"). The Physician's and Surgeon's Certificate was in full force and
24 effect at all times relevant to the charges brought in this Accusation and will expire on June 30,
25 2000, unless renewed.

26 3. On or about December 22, 1999, a partial interim suspension order was
27 issued against Dr. Liebman prohibiting him and all members of his office staff from dispensing
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1 or administering any vaccine or inoculant pending a final decision and order by the Medical
2 Board on this Accusation.

3 JURISDICTION

4 4. This Accusation is brought before the Medical Board of California
5 ("Medical Board" or "board"), under the authority of the following sections of the Business and
6 Professions Code ("Code").

7 5. Section 2227 of the Code provides that a licensee who is found guilty
8 under the Medical Practice Act may have his or her license revoked, suspended for a period not
9 to exceed one year, placed on probation and required to pay the costs of probation monitoring, or
10 such other action taken in relation to discipline as the Division deems proper.

11 6. Section 2234 of the code provides in pertinent part that "the Division of
12 Medical Quality shall take action against any licensee who is charged with unprofessional
13 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is
14 not limited to, the following:

- 15 (a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting
16 the violation of, or conspiring to violate, any provision of this chapter.
- 17 (b) Gross negligence.
- 18 (c) Repeated negligent acts.
- 19 (d) Incompetence.
- 20 (e) The commission of any act involving dishonesty or corruption which is
21 substantially related to the qualifications, functions, or duties of a physician and
22 surgeon."

23 7. Business and Professions Code section 2238 provides that a violation of
24 any federal statute or federal regulation or any of the statutes or regulations of this state
25 regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

26 8. Health and Safety Code section 111300 provides that it is unlawful for any
27 person to adulterate any drug or device.

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1 FACTS

2 19. At all times relevant to this matter, Dr. Liebman has practiced as a
3 pediatrician in San Rafael and Novato, California.

4 20. In or about September 1998, one of Dr. Liebman's employees became
5 suspicious that someone was tampering with the vaccine vials. She noted that she was recording
6 the same lot numbers and dates of expiration for vaccines for what seemed like excessive periods
7 of time and that the rubber stoppers on some of the vials were bulging.

8 21. In or about March 1999, this employee began marking vaccine vials with a
9 pen to note the level of fluid in the vial at the end of the day. The following day, she would find
10 that the fluid in the marked vials had increased. In addition, she found many more needle
11 punctures in the stoppers of some of the vaccine vials than the number of doses in the vials.

12 22. In or about June 1999, the employee seized two of the non-conforming
13 vials and delivered them to the Medical Board. The vials contained Hepatitis B vaccine. They
14 were labeled CI-1 and CI-2 for identification.

15 23. On June 10, 1999, the Marin County District Attorney's Office ("Marin
16 DA") served a search warrant at Dr. Liebman's San Rafael office and seized the following
17 evidence: all open vials of vaccine, three samples of closed vaccines for comparison purposes, a
18 large sampling of patient records, all office computers, Dr. Liebman's order book, billing records,
19 sign in sheets, and appointment schedules. The vials of vaccine were labeled K1 through K14
20 for identification.

21 24. On June 11, 1999, the Marin DA served the search warrant at Dr.
22 Liebman's Novato office and seized all open vials of vaccine from the office refrigerator. These
23 vials of vaccine were labeled KH1 through KH5 for identification.

24 25. The vials of vaccine were sent to the Federal Drug Administration Center
25 for Biologics Evaluation and Research in Maryland for analysis. For each complaint sample, an
26 unopened vial of the same lot and product was obtained by the laboratory and used as a control
27 or for comparison to the corresponding complaint vial.

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26. Eleven of the 21 complaint samples submitted did not have the same chemical test results as their respective control samples: K5 (Hepatitis B), K6 (Tetramune), K9 (TD), K10 (Injectable Polio Virus), K11 (Influenza Virus), KH1 (Influenza Virus), KH2 (Hepatitis B), KH3 (Polio Virus), KH4 (DT), CI-1 (Hepatitis B), and CI-2 (Hepatitis B) had been adulterated.

27. The analysis found benzyl alcohol in seven of the eleven non-conforming complaint samples. Benzyl alcohol is not a preservative in any of the licensed sample products. The results from ICP/mass spectrometric semi-quantitative analyses for sodium and chloride concentrations indicated that either water or water containing sodium chloride was added to the other four non-conforming complaint samples.

28. The number of punctures in the rubber stoppers in the non-conforming vials greatly exceeded the number of doses available in the vials. The ratio of actual punctures to doses available are as follows: 26/12 (K5--Hepatitis B), 32/10 (K6--Tetramune), 17/10 (K9--TD), 24/10 (K10--Injectable Polio Virus), 30/10 (K11--Influenza Virus), 33/10 (KH1--Influenza Virus), 60/12 (KH2--Hepatitis B), 24/10 (KH3--Polio Virus), 26/10 (KH4--DT), 20/12 (CI-1--Hepatitis B), and 16/12 (CI-2--Hepatitis B).

29. Thimerosal is used as a chemical preservative in these vaccines. The amount of the thimerosal in the contents of the complaint vials was analyzed by cold vapor atomic absorption spectroscopy through the determination of the mercury content present. Nine out of the eleven complaint vials did not contain the amount of thimerosal analyzed to be in the appropriate control vials as the label claim values. In terms of percent, the thimerosal content of the complaint vials, CI-1, CI-2, K5, K6, K9, K11, KH1, KH2, and KH4 were equal to or less than 0.2%, 7.1%, 0.0%, 0.0%, 16.5%, 0.0%, 0.0%, 68.2%, and 0.0%, respectively.

30. Aluminum is used in the formulation of certain vaccines and gives a cloudy white appearance to the liquid vaccines. Seven of the non-conforming complaint sample vials, CI-1, CI-2, K5, K6, K9, KH2, and KH4, contain aluminum in their licensed formulation. The aluminum content in these complaint vials was equal to or less than 3.6%, 25.5%, 11.3%, 30.5%, 16.0%, 53.6%, and 20.1%, respectively, of the aluminum content of the control vials.

1 Moreover, CI-1, CI-2, K5, K6, and KH4 were clear in appearance indicating that the aluminum
2 adjuvant compound which should have been visible in the vial as a white suspension was not
3 present at the licensed concentration.

4 31. During the period from January 1997 to May 1999, the vaccinations
5 administered in Dr. Liebman's offices were given either by Dr. Liebman or by a nurse
6 practitioner, a registered nurse, or a certified nursing assistant.

7 32. When a vaccination was given, the following information was documented
8 in the progress notes in the patient's chart: the vaccine name, dosage, location of shot,
9 manufacturer, lot number, and expiration date. The person giving the injection was required to
10 sign his or her name after the documentation.

11 33. The date of the vaccination was also documented on the immunization
12 chart on the front of the patient's file.

13 34. Except for several very short periods when Dr. Liebman was away from
14 the office, Dr. Liebman himself ordered all the vaccines for his offices for at least the two year
15 period preceding June 1999.

16 35. In April 1999, Dr. Liebman was out of the office for two weeks on Naval
17 Reserve duty and a locum tenens was working in his place. Although there had been no changes
18 in the amounts of vaccine ordered prior to Dr. Liebman's absence or the number of patients seen
19 during his absence, the office quickly ran out of vaccine several times during this two week
20 period and had to obtain additional vials of vaccine on an urgency basis.

21 36. Further proof that some of Dr. Liebman's vaccines have been diluted is
22 provided by the substantial disparity which exists between the amounts of Hepatitis B vaccine,
23 Tetramune, DTP vaccine, DTaP vaccine, and Injectable Polio Vaccine dispensed by Dr.
24 Liebman's office between January 1997 and May 1999 and the quantities of these vaccines the
25 office had available during that time.

26 37. The number of each type of vaccination given between January 1997 and
27 May 1999 has been calculated from the billing records seized from Dr. Liebman's office. These

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1 records reveal the procedure codes for the various types of vaccinations, patient identification
2 numbers, and dates of vaccinations.

3 38. The types and quantities of all vaccines received by Dr. Liebman's office
4 between January 1997 and May 1999 have been obtained from his pharmaceutical vendors and
5 from the California Health Department Program which provided him with free vaccines. The
6 pharmaceutical vendors from whom Dr. Liebman purchased his vaccines were identified from
7 Dr. Liebman's "Order Book," information obtained directly from Dr. Liebman, vaccine invoices
8 obtained from Dr. Liebman's wife, Dr. Liebman's business check register, and Dr. Liebman's
9 business bank records subpoenaed from the Bank of America.

10 39. The billing records reflect that Dr. Liebman's office administered 1604
11 doses of Tetramune between January 1997 and May 1999. During this same period, the records
12 reflect that Dr. Liebman's office received only the equivalent of 185 doses of Tetramune. This
13 reflects a shortfall of 1419 doses of Tetramune.

14 40. The billing records reflect that Dr. Liebman's office administered 141
15 doses of DTP vaccine between January 1997 and May 1999. During this same period, the
16 records reflect that Dr. Liebman's office received no DTP vaccine. This reflects a shortfall of
17 141 doses of DTP vaccine.

18 41. The billing records reflect that Dr. Liebman's office administered 169
19 doses of Injectable Polio Vaccine between January 1997 and May 1999. During this same
20 period, the records reflect that Dr. Liebman's office received only the equivalent of 60 doses of
21 Injectable Polio Vaccine. This reflects a shortfall of 109 doses of Injectable Polio Vaccine.

22 42. The billing records reflect that Dr. Liebman's office administered 386
23 doses of DTaP vaccine between January 1997 and May 1999. During this same period, the
24 records reflect that Dr. Liebman's office received only the equivalent of 190 doses of DTaP
25 vaccine. This reflects a shortfall of 196 doses of DTaP vaccine.

26 43. The age of the patient is irrelevant to this analysis because the prescribed
27 dosage for Tetramune, DTP vaccine, Injectable Polio Vaccine, and DTaP vaccine is the same
28 regardless of the age of the recipient.

1 44. Determining whether there was a disparity between the amount of
2 Hepatitis B vaccine dispensed and the amount possessed was not as straight-forward as with the
3 other vaccines. This is because, with Hepatitis B vaccine, dosages are age related and also
4 because the two brands of Hepatitis B vaccine used by Dr. Liebman have different dosage/age
5 relationships.

6 45. The purchase records and invoices of Hepatitis B vaccine received by Dr.
7 Liebman between January 1997 and May 1999 reflect that he purchased primarily Recombivax-
8 HB, the brand name for Hepatitis B vaccine produced by Merck & Co. He also purchased, or
9 received, Engerix-B, the brand name of Hepatitis B vaccine produced by Smith Kline Beecham.

10 46. Recombivax-HB comes in three strengths: Pediatric (2.5 mcg in .5 ml),
11 Risk/Adolescent (5 mcg in .5 ml), and Adult (10 mcg in 1 ml). The recommended doses of
12 Recombivax-HB are as follows:

13 0-10 years of age	2.5 mcg per .25 ml or .5 ml shot
14 11-19 years of age	5 mcg per .5 ml shot
15 20 + years of age	10 mcg per 1 ml shot

16 47. The purchase records reflect that Dr. Liebman primarily purchased 3 ml
17 multi-dose vials of adult Recombivax-HB. One vial contains 3 adult doses of 1 ml each, 6
18 adolescent doses of .5 ml each, 12 doses of .25 ml each, or any combination of these doses which
19 adds up to 3 ml.

20 48. Engerix-B comes in pediatric and adult formulations of the following
21 doses:

22 0-19 years of age	.5 ml of vaccine
23 20 + years of age	1 ml of vaccine

24 49. As noted in paragraph 37, above, Dr. Liebman's billing records contain the
25 patients' identification numbers, the procedure codes for all types of vaccinations including
26 Hepatitis B, and the dates the patients were vaccinated. Dr. Liebman's computerized patient list,
27 also seized from his office, contains the patients' identification numbers and dates of birth. By
28 combining the information from these two sources, a complete list of Hepatitis B vaccinations

1 given by Dr. Liebman's office between January 1997 and May 1999 could be generated, arranged
2 by patient identification number, date of vaccination, and age of patient at the time of the
3 vaccination.

4 50. From this composite list, it was determined that Dr. Liebman's office
5 billed for 3210 Hepatitis B vaccinations between January 1997 and May 1999. Of those
6 vaccinations, 2249 were given to patients between the ages of 0 and 10.99 years, 764 were given
7 to patients between the ages of 11 and 18.99 years, 22 were given to patients over the age of 20,
8 and 175 were given to patients not identified by age.

9 51. While the records do not reveal which patients received Recombivax-HB
10 vaccine and which Engerix-B, the only group for whom the different vaccines would affect the
11 dosages given are children between 0 and 11 years of age. Children in this age group would
12 generally have been given only .25 ml of vaccine if they received the adult Recombivax-HB but
13 would have received .5 ml if they were given pediatric Recombivax-HB or Engerix-B. Although
14 it will somewhat understate the amount of vaccine administered, for purposes of comparing the
15 amounts of vaccine administered with the amounts available to administer, all of the children
16 from 0 to 10.99 years of age were considered to have been given only .25 ml.

17 52. In the same way, the 175 patients for whom birth dates are not available
18 are also considered to have received only .25 ml of vaccine in each injection even though it is
19 most likely that some of them received .5 ml or 1 ml doses.

20 53. Using these assumptions, the billing records reflect that Dr. Liebman's
21 office administered 1010 ml of Hepatitis B vaccine between January 1997 and May 1999.
22 During this same period, the records reflect that Dr. Liebman received only 476 ml of Hepatitis B
23 vaccine, less than half the amount allegedly administered.

24 54. The number of vaccine vials Dr. Liebman was ordering between January
25 1997 and May 1999 contained significantly fewer doses than the number of vaccine doses which
26 he and his staff were administering to patients during that time period.

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1 55. Dr. Liebman transported various vaccines between his two offices in a
2 paper bag which he did not keep refrigerated. He also administered vaccines directly from the
3 bag.

4 56. All vaccines must remain either refrigerated or frozen, depending on the
5 specific manufacture recommendations, at all times except for the immediate pre-administration
6 preparation. If the vaccines exceed the recommended temperature they will lose their efficacy.

7 57. On or about November 23, 1999, after the Marin DA advised Dr. Liebman
8 that they intended to file charges against him, Dr. Liebman advised his patients that there was a
9 possibility that some or all of the vaccines they had received at his office may have been
10 ineffective. He offered them the opportunity to have their blood tested at Unilab to determine if
11 they had developed sufficient antibodies.

12 58. Of the 362 of Dr. Liebman's patients who had their antibodies tested at
13 Unilab, 134 of them had received all three of their Hepatitis B shots at Dr. Liebman's offices
14 between January 1, 1996 and April 30, 1999 and had received at least one of the shots between
15 January 1, 1997 and April 30, 1999.

16 59. Of those 134 patients, 43 were immune to Hepatitis B, 1 was borderline,
17 and 90 were not immune to Hepatitis B. That is, 68.2% of those patients were not immune to
18 Hepatitis B.

19 60. Typically, no more than 5% of patients receiving three full doses of
20 Hepatitis B vaccine will fail to show immunity to Hepatitis B.

21 61. Dr. Liebman did throat cultures for Group A, *B* Hemolytic Streptococcus
22 in his office and frequently swabbed specimens from more than two patients and sometimes as
23 many as six patients on a single blood agar culture plate.

24 62. Plating more than two specimens on a single blood agar culture plate for
25 the purpose of determining the presence of Group A, *B* Hemolytic Streptococcus is improper.

26 63. Dr. Liebman routinely reused plastic urine cups which were used to obtain
27 urine samples for urinalysis and urine culture, instructing his staff to wash the cups in

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antibacterial soap and/or germicidal cleaning solution, rinse them, put them on a paper towel to dry, and then store them in a drawer without the screwtop lids attached.

64. A specimen cup which has been properly cleaned in a germicidal solution and dried in a clean, non-contaminated area with the screwtop lid replaced to ensure cleanliness would be within the standard of care for obtaining urine for urine dipstick or urinalysis.

65. It is absolutely necessary, however, that a urine specimen for a urine culture be collected in a sterile specimen container.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Incompetence)

66. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234 for unprofessional conduct pursuant to subsections (a) (violating provisions of this chapter), (b) (gross negligence), (c) (repeated negligent acts), and/or (d) (incompetence) in that, for a period of more than two years, he intentionally diluted the Hepatitis B vaccine, Tetramune vaccine, DTP vaccine, DTaP vaccine and Injectable Polio Vaccine which were administered to his patients as more particularly alleged in paragraphs 19 through 65, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Incompetence)

67. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234 for unprofessional conduct pursuant to subsections (a) (violating provisions of this chapter), (b) (gross negligence), (c) (repeated negligent acts), and/or (d) (incompetence) in that, if he did not personally dilute the Hepatitis B vaccine, Tetramune vaccine, DTP vaccine, DTaP vaccine and Injectable Polio Vaccine which were administered to his patients over a period of more than two years, he failed to realize quickly that someone else was diluting them based on the fact that the number of vaccine vials he was ordering was significantly less than the number of vaccine doses which he and his staff were administering to patients as more particularly alleged in paragraphs 19 through 65, above.

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1 **SIXTH CAUSE FOR DISCIPLINE**

2 (Adulteration of Drugs)

3 71. Respondent's certificate to practice medicine is subject to disciplinary
4 action for unprofessional conduct under Business and Professions Code section 2238
5 (unprofessional conduct to violate drug laws) for violating Health and Safety Code section
6 111300 (unlawful to adulterate any drug) in that, for a period of more than two years, he
7 intentionally diluted the Hepatitis B vaccine, Tetramune vaccine, DTP vaccine, DTaP vaccine
8 and Injectable Polio Vaccine which were administered to his patients as more particularly alleged
9 in paragraphs 19 through 65, above.

10 **SEVENTH CAUSE FOR DISCIPLINE**

11 (Misbranding Drugs)

12 72. Respondent's certificate to practice medicine is subject to disciplinary
13 action for unprofessional conduct under Business and Professions Code section 2238
14 (unprofessional conduct to violate drug laws) for violating Health and Safety Code sections
15 111345 (unlawful to misbrand any drug) and 111340 (unlawful to hold, deliver, or sell any
16 misbranded drug) in that he misbranded vaccines as defined in Health and Safety Code section
17 111395 (drug is misbranded if all or part of the contents of the original package have been
18 removed and replaced with other material) and held, delivered, and sold the misbranded vaccines
19 as more particularly alleged in paragraphs 19 through 65, above.

20 **EIGHTH CAUSE FOR DISCIPLINE**

21 (Dishonesty)

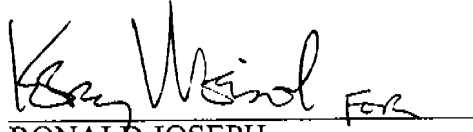
22 73. Respondent's certificate to practice medicine is subject to disciplinary
23 action under Business and Professions Code section 2234 for unprofessional conduct pursuant to
24 subsection (e) (dishonesty) in that he intentionally diluted the Hepatitis B vaccine, Tetramune
25 vaccine, DTP vaccine, DTaP vaccine and Injectable Polio Vaccine which were administered to
26 his patients and he misbranded vaccines as defined in Health and Safety Code section 111395
27 and delivered the misbranded vaccines to his patients as more particularly alleged in paragraphs
28 19 through 65, above.

1 PRAYER

2 WHEREFORE, Complainant requests that a hearing be held on the matters herein
3 alleged, and that following the hearing, the Division of Medical Quality of the Medical Board
4 issue a decision:

- 5 1. Revoking or suspending Physician's and Surgeon's Certificate Number G
6 12827, issued to William Liebman, M.D.;
- 7 2. Ordering William Liebman, M.D. to pay the Division the reasonable costs
8 of the investigation and enforcement of this case, and, if placed on probation, the costs of
9 probation monitoring;
- 10 3. Taking such other and further action as deemed necessary and proper.

11 DATED: JUNE 9, 2000

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13 
14 RONALD JOSEPH
15 Executive Director
16 Medical Board of California

17 State of California
18 Complainant
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